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DATE NOTICE SENT TO ALL PARTIES: Nov/10/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Left L5-S1 transforaminal injection with IV sedation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Family Medicine

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is this reviewer's opinion that medical necessity for the request for Left L5-S1 transforaminal injection with IV sedation has not been established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who was injured on XX/XX/XX when she slipped and fell injuring her low back. The patient initially presented with right sided muscle spasms and low back pain. Initial treatment was inclusive of muscle relaxants, anti-inflammatories and extensive physical therapy. The patient continued to describe low back pain despite conservative treatment. The patient also endorsed pain in the left lower extremity with associated numbness and tingling. MRI studies of the lumbar spine from slight disc desiccation and disc height loss at L5-S1. There was a 6 mm disc osteophyte complex impressing the anterior thecal sac greater to the left of midline. There were degenerative facet joint changes noted. There was asymmetric extension of the disc and spur to the left neural foramen with severe narrowing possibly compromising the left L5 nerve root. The patient was followed for ongoing low back and left lower extremity complaints. The clinical report noted painful and restricted lumbar range of motion. Strength and sensation was intact in the lower extremities. No reflex changes were reported. The recommended L5-S1 epidural steroid injection with IV sedation was denied by utilization review on as the patient had no specific physical examination findings indicative of radiculopathy and there were no indications regarding IV sedation. The request was again denied on due to the lack of objective findings regarding radiculopathy or indications for sedation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for complaints of low back pain radiating to the left lower extremity. MRI studies did note significant left sided foraminal stenosis and potential impingement of the S1 nerve root due to a combination of a disc osteophyte complex and degenerative changes. The patient's physical examination findings were unremarkable for any focal neurological deficits in an L5-S1 distribution. No other supportive evidence for an active lumbar radiculopathy was available for review such as electrodiagnostic studies. The records also did not identify any procedural anxiety or needle phobia to the extent that IV sedation would be required. Per

guidelines, IV sedation is not typically indicated in epidural steroid injections unless there is significant procedural anxiety present. As the clinical records provided for review do not meet guideline recommendations regarding the proposed procedures, it is this reviewer's opinion that medical necessity for the request for Left L5-S1 transforaminal injection with IV sedation has not been established and the prior denials remain upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)